Associates in Dentistry

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Patient's Chart Number:** _____

I request and authorize Associates in Dentistry to use and disclose my personal and health information. This may include claims and billing information. It may also include medical records that Associates in Dentistry has received from medical and/or dental practitioners.

Type of Information Associates in Dentistry may release (check ONE):

____ All of my information (including personal, health, demographic, claims, billing and medical records

OR

____ Only my claims and billing information **OR**

____ Other, such as information regarding a specific date of service or issue (**SPECIFICY**) _____

_____

The following person(s) may receive this patient's information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Revocation of Authorization:

I have the right to revoke this Authorization in writing at any time by sending such written notification to Privacy Contact Person at Associates in Dentistry, except to the extent that Associates in Dentistry has already used or disclosed the information in reliance on this Authorization.

Expiration Date:

Unless revoked earlier, this Authorization will expire (choose ONE):

_____ On the following date: _____ **OR**

_____ When patient notifies Associates in Dentistry they no longer wish to be a patient or when Associates in Dentistry notifies patient they will no longer be providing services. The Authorization shall

remain in effect for the period reasonably needed to complete any request before the termination notice.

I understand that Associates in Dentistry cannot condition treatment, payment, enrollment or eligibility for benefits based on the receipt of this signed Authorization.

I understand that I may refuse to sign the Authorization; and

I understand that I am entitled to a copy of this Authorization.

I understand that the persons to who information is disclosed under this Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.

Signature of Patient or Patient's Personal Representative:

_____ Date: _____

If Personal Representative:

Print Name: _____

Signature: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

Copy of signed authorization provided to the individual:

Date: _____

Initials: _____